# *IMAGING REQUEST & REFERRAL FORM*

Collin County
VETERINARY IMAGING
Center

Clinic Name: _____

Referring Veterinarian: _____

Date: _____ Clinic phone: _____

Email address: _____

Owner Name: First_____ Last_____

Phone Number: _____Secondary Phone Number_____

Patient Name: _____ Age: _____ Breed: _____

Wt. _____lb./kg. (circle one) Sex: Neutered Male / Spayed Female / Male / Female (circle one)

Patient History:

**Ultrasound:** (circle one) Abdominal / Echocardiography (heart only)
Do you recommend sedation based on patient history? (circle one) Yes / No / Not Sure

**Computed Tomography:** (circle one) Head and neck / Abdomen / Pelvis / Thorax / Spine / Extremities

☐ **YES, I consent to CT-SCAN Contrast Media Administration (Additional Charges may apply)**

**For a complete assessment, please send any recently performed imaging including radiographs with the patient regardless of desire for radiographic consultation. For CT imaging with contrast please include recent (within 6 months) blood work including renal profile. Preliminary ultrasound results may be available the same day and radiology consultation for both ultrasound and CT are typically available within 24-48 hours.**

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